Enrollment Election Form

Salary Reduction Agreement

Employer:		Plan Year:
Employee	Social Security No.	Date of Birth
Home Address	City	State & Zip
Deduction Period ☐ Weekly 52 ☐ Bi-Weekly 26 ☐ Semi-Monthly 24 ☐ Monthly 12	Payroll Salaried☐ Hourly ☐	W-2: N/A
Date of Hire Key Employee Yes☐ No☐		

Benefit	Pretax Per Pay Period	After Tax	Annual Pledge
Health Premium			
Unreimbursed Medical			
Dependent Care			
Total			

____ With regard to my salary reduction agreement and my election of benefits, I understand and agree that:
I may not change elections during the Plan Year unless there is a change in my family status (e.g. marriage, divorce, death, birth or change in employment of spouse)

_____I understand that any amounts remaining in my flexible spending account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws.

_____Any dependents for which I have selected the dependent care benefit reside with me in a parent-child relationship and/or are legally dependent on me for support.

My Social Security Benefits may be slightly reduced as a result of my election. The Employer may reduce or cancel the election of any non-taxable benefit or otherwise modify my election in accordance with the Plan. If the Employer, in its discretion, deems that action advisable to satisfy the requirements of the Internal Revenue Code or the regulations thereunder.

AUTHORIZATION I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown on this form under the column heading "Pretax". I further authorize future adjustment in the amount of the salary reduction in the event that the cost of coverage in any program selected is changed during the plan year.

I certify the above information to be correct and true and any dependents for which I have selected the dependent care benefit reside with me in a parent-child relationship and /or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws.

Employee Signature _____ _____
Date

YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained and I decline to participate.

Employee Signature _____ _____

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Non-Flexible Benefits Plan

AUTHORIZATION: I hereby authorize my Employer to deduct from my salary until further notice the amount necessary to pay for the coverage shown on the front of this form under the column heading "After Tax". Such deductions shall commence with my paycheck beginning the plan year stated on the front of this form.

I understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization on my part, verbal or written, provided the insurance company above certifies in writing that the change in premium uniformly affects all members of the class to which I belong.

I agree not to hold my Employer responsible in the event a premium payment is not made when due to the Insurance Company.

Employee Signature _____ _____